

VENEREAL DISEASES IN THE BRITISH-OCCUPIED ZONE OF GERMANY*

BY

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Before discussing the situation with regard to venereal diseases in the British Zone of Germany after the end of hostilities in Europe, it is desirable to describe the situation before this date.

German Public Health Organization

Even before the Nazi régime the German organization had shown strong tendencies to increase the power of central government at the expense of local government, and this tendency was intensified by the Nazis. The German central government had no separate ministry of health, but all medical matters were controlled and directed by Department 4 of the Ministry of the Interior. The head of the department was usually a medical man, who, in matters of health, advised the Minister of Interior but had no direct access to the Cabinet. This department was responsible for far wider medical activities than the Ministry of Health in the United Kingdom. Not only public health, but medical associations, medical education, and the control of narcotics were functions of Department 4.

Below the central government, Germany was divided into states, such as Prussia, the governments of which formerly possessed considerable autonomy. These states, in turn, were divided into provinces, such as Schleswig-Holstein and Westphalia in the British Zone. These provinces were, as a rule, subdivided into government districts, which were again divided into local government areas called Kreise, some of which were urban and some rural. Each Kreis had a medical officer of health, who, in theory, had great powers and responsibilities, but, unlike his counterpart in the United Kingdom, he was not furnished with sufficient trained staff to carry out his tasks. For example, the medical officer of health had no sanitary inspectors and few health visitors. Much of the disposal of human excreta was farmed out to contractors, who in some parts of Germany handled 80 per cent. of this work, but the collection and disposal went on with no

inspection by the medical officer of health. Further, the posts were not very well paid and did not, therefore, attract the best type of medical man.

Much of the work carried out in the United Kingdom by the staff of the medical officer of health was in Germany performed by the police. For example, there was a branch of the police called the Sanitary Police, whose training was frequently very sketchy and mostly on the apprenticeship basis. It was their responsibility to inspect and report on nuisances, restaurants, cafés, food, etc. Similarly, as we shall see, the police handled those problems in connexion with venereal disease which are dealt with in the United Kingdom by health visitors and social service workers.

THE VENEREAL DISEASE PROBLEM

The German law as amended by Hitler's government clearly laid on the medical officer of health the responsibility for dealing with the venereal disease problem, but in fact very little of it was handled by him. The greater part of the total number of cases of venereal disease was treated by private practitioners, in either specialist or general practice. This situation was due to the widespread system of sickness insurance, which included between 80 and 90 per cent. of the population, and to the fact that treatment of venereal disease was included in sickness insurance. Naturally, a small percentage of people drawn from the more well-to-do classes preferred to pay for their treatment; and these always consulted the specialist. On the other hand, there was a small percentage who either were not insured or not in benefit, and whose venereal disease treatment was a charge on public funds. These patients might still be treated privately or they might be referred to a hospital.

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It is obvious that in such a system there was no incentive for central or local government to set up public clinics as has been done in the United Kingdom. Venereal disease cases could, if they wished, attend the out-patient departments of the university hospital or of the municipal hospitals in the large towns, but usually few chose to do so unless they developed complications for which hospitalization was a necessity.

In Germany there was no separation between the specialties of dermatology and venereal disease. To become a specialist in these subjects demanded four years' postgraduate training in one or more university hospitals. The training was intensive and extensive in the clinical and therapeutic aspects, but in relation to venereal disease there was a noticeable lack of attention to the public health aspect. Once a doctor had become a recognized specialist he might remain in his university town, holding a university appointment as well as practising privately; or he might set up in private practice in any large town, with or without a hospital appointment. In either case he would almost always be working essentially as a private individual not connected in any way with the local public health department.

Turning to the more technical aspects of venereal disease it is convenient to consider syphilis and gonorrhoea separately under the headings of diagnosis, treatment, and tests of cure.

Syphilis

Diagnosis.—Dark-field examination of serum obtained from chancres, secondary eruptions, condylomata, etc. is the standard procedure in Germany, and in most cases it is carried out by the examining specialist in his own consulting room. This is one of the techniques which the general practitioner seldom possesses, and the latter generally refers the patient to a specialist or, very occasionally, sends some serum enclosed in a capillary tube to a laboratory for dark-field examination.

Blood examinations for syphilis are carried out as a routine; those commonly used are the Wassermann reaction and the Meinicke or Klein or Kahn test. In some laboratories and hospitals the Chediak method is regarded with great favour as being rapid and giving fairly accurate results. All doubtful results from this method are checked by a subsequent Wassermann reaction.

Treatment.—Cases of fresh syphilis with dark-field

examination positive and Wassermann test negative are treated by (1) one course of 12 intravenous injections of neosalvarsan (0.6 g. each injection) in the first 6 weeks, (2) simultaneously with the neosalvarsan, one course of bismuth intramuscularly for a total of 12 injections, (3) a rest period of 6 weeks, (4) a repeat of the above courses of arsenic and bismuth, alternating with rest periods of 6 weeks until the Wassermann reaction and spinal fluid are both negative. Three courses of arsenic and bismuth in 12 months usually suffices for a serological cure. Cases of fresh syphilis with both dark-field examination and Wassermann tests positive are given the same routine treatment, but usually lasting 18 to 24 months.

Latent syphilis is treated by alternating courses of treatment and rest as for fresh syphilis for 24 months, or until serological and spinal fluid tests become negative.

Cases of paresis are given neosalvarsan by intravenous injection and bismuth by intramuscular injection, alternating with rest periods as for fresh syphilis—this treatment following upon the induction of malaria by the bite of an infected mosquito. Direct injection is preferred to the injection of infected blood because the reaction is more uniform.

Tests of Cure.—At the conclusion of treatment Wassermann tests are made every 3 months during the first year; at the end of the first year the spinal fluid is tested. During the second year the blood test is done during the sixth and the twelfth month. A positive report at any time calls for resumption of treatments, which generally means two or more courses of arsenic and bismuth. All tests being negative at the end of two years of observation following the cessation of 1 year's treatment, the case is considered definitely cured. Marriage is allowed for such "cured" cases.

No penicillin had been used before the British occupation.

Gonorrhoea

Diagnosis.—Smears from urethra and cervix are taken and stained with methylene blue by Loeffler's method. This is a technique which British venereologists are taught to eschew in favour of Gram's staining method or one of its modifications. Having been in many of the German clinics and laboratories, however, and examined many stained specimens under the microscope *pari passu* with the German clinicians and pathologists, I am convinced that, provided the person carrying out the examination has had sufficient training and experience, the methylene blue method gives as good results in German hands as Gram's method in British hands. Moreover, in all doubtful cases the Germans are accustomed to use Gram's method as an alternative.

In regard to cultures of material from urethra and cervix, the German practice appears to vary. In university skin and venereal disease departments cultures were routine, though under present conditions there is such a shortage of material for making the culture medium that few clinics are able to continue the routine. Apart from the university departments, the larger hospitals usually had cultures made as part of the routine examination, but the smaller hospitals, the general practitioners, and most of the private venereal disease specialists were not in the habit of examining by culture.

The Germans either know little or nothing about the employment of the gonococcal complement fixation test on samples of blood drawn from patients, or they do not think that the test yields any significant information.

Treatment.—The general tendency in Germany for the past two or three years has been to use sulphathiazole (marketed under trade names such as eleudron, cibazol, etc.), but most German venereologists are somewhat hazy about the best methods of using the drug because they have had no opportunities for research and no access to publications from abroad. Those German venereologists whose standard of skill in the use of sulphathiazole is high give a routine course of treatment of 15 tablets on the first day, 12 on the second, 10 on the third, and 8 on the fourth, a total of 22.5 g. in 4 days. This is frequently followed at a week's interval by a similar course as an insurance, especially in women. British venereal disease specialists would be inclined to think that the total given is not great enough, and that the treatment should last 5 days instead of 4, but from the case records which have been studied the above method seems to give reasonably good results.

As is the case all over the world, successful results of sulpha treatment have tended to decrease owing to the development of sulpha-resistant strains of gonococci. The German venereologists state that about 40 % of their cases of gonorrhoea are sulpha-resistant, i.e. are not cured by one such course as above described. They are accustomed in such cases to induce fever in the patient by injection intravenously of foreign protein, or, in some cases, 1 or 2 c.cm. of a 40 % solution of oil of turpentine may be injected into the muscles of the buttock. This procedure is somewhat painful and produces temperatures in the region of 103–4° F. At the height of the fever, or immediately after, sulphathiazole is given in amounts of 15 tablets a day by mouth, and this is sometimes accompanied by the intravenous injection of 10 c.cm. of a 20 % solution of sulphathiazole. By means of these rather heroic measures they claim that, of the 40 % of sulpha-resistant cases, half are cured. This leaves 20 % of all cases

for which the methods of treatment current before the discovery of the sulpha group of drugs must be used.

Apart from sulphathiazole the Germans use protargol, silver nitrate, izal, mercurochrome, and similar antiseptics for local application. Before the British occupation the Germans had no experience of penicillin for the treatment of gonorrhoea.

Tests of Cure.—Apart from a disinclination to use cultures, the German venereal disease specialists adopt much the same criteria as are accepted in the United Kingdom and the United States of America. Examination of the urethra by means of the urethroscope, massage of the prostate and microscopic examination of stained specimens of the expressed fluid, and, in many cases, provocative agents such as the intravenous injection of a gonococcal vaccine (the last a procedure of doubtful utility) make up the general test for cure in the male. German venereal disease specialists are very devoted to provocative methods as part of the test of cure and carry them to limits far beyond any that would be thought suitable in the United Kingdom. For example, within 4 to 6 days after completing treatment the male patient is submitted to massage over a straight sound and to dilatation with Kollmann's dilator. In addition, Lugol's solution, diluted 1 in 4, or 3% hydrogen peroxide are instilled into the urethra and retained for up to 5 minutes. Women are not submitted to mechanical provocatives, but concentrated Lugol's solution is injected into the cervix. In addition, in both sexes, intravenous injection of gonococcal vaccine is used as a provocative.

Public Health and Legal Aspects

Incidence.—Cases of venereal disease have never been notifiable, i.e. by names and addresses; nor, even, has reporting only in terms of numbers been the law in Germany. So the determination of the number of fresh cases of venereal disease occurring each year was largely a matter of guesswork. On occasion, by special Reich decree, a census of fresh venereal disease cases has been ordered to take place in a named month of the year, but this appears to have been done recently only in 1934 and 1940. From the figures so obtained a calculation of the venereal disease incidence for the particular year and for intervening years has been made. The results, however, can hardly be considered satisfactory, since the incidence in Germany was reported to be lower in the early years of the war than before the war, at a time when, in every other

country where records were available, there was found to be an increase.

The standard law on venereal disease in Germany is the Law of 1927, in which there is no provision for a return by the doctors of the number of fresh cases of venereal disease seen by them.

Case Finding.—There has been in Germany an obligation on doctors who see fresh cases of venereal disease to try to find the source of each infection and to get the person examined and, if necessary, placed under treatment. This obligation has apparently had no specific legal basis but has been a professional duty laid upon doctors by the *Arztekammer*, the Medical Association. This appears to be the situation so far as Reich legislation is concerned, but individual states or *Länder* have introduced their own laws, not only on this point but also on the reporting of fresh cases.

Investigation of the system of source-finding or contact-tracing as actually practised in the British Zone brought to light two methods which, together with a third method, of doing nothing at all, appear to have been the custom. In the first method a doctor would diagnose that Mr. A. had venereal disease and would question him as to a possible infectious source; if he succeeded in eliciting a name and address, he would write to the woman and tell her she should either come to him for examination or, if she chose to go to another doctor, should send a certificate to the former doctor. If neither attendance nor certificate were forthcoming within a reasonable time, the first doctor would then send the woman's name and address to the Health Office of the area in which she resided. The medical officer of health would then write to the woman telling her of the circumstances and inviting her to present herself for examination either at a centre named by the medical officer of health or by a private venereal disease specialist. If no notice were taken of this, the name and address would be sent to the police and the woman would then be arrested (if found), flung into prison, compulsorily examined and, if necessary, treated, generally in hospital.

In the second method, the doctor first seeing a fresh case would get the name and address of the infectious source and transmit this

information direct to the Health Office; the procedure would then be the same as in the first method.

The third method, that of doing nothing at all, appears to have been much the most commonly used, except in the case of venereal disease specialists working at the universities and some of the more responsible privately practising specialists; these venereologists tried to carry out their professional obligations and their duty as citizens.

In the absence of records of the number of fresh cases of venereal disease seen by an individual doctor, it is, of course, impossible to assess the ratio of infectious sources reported by him to the number of cases seen, and therefore impossible to judge of the doctor's zeal in source-finding. It is not improbable that many sources were not even inquired for, or that, if they were discovered, the knowledge was suppressed for one reason or another.

Failure to maintain attendance for treatment and/or observation is an offence under the Venereal Disease Law of 1927, and the same law compels the doctor first to attempt to get the patient to return to him, and, if that fails, to notify the Health Office, which then attempts by letter to secure the same end and calls in police action if that in turn fails. As it is part of the same law that a patient who knows he has venereal disease must be treated, there is an adequate legal basis for securing case-holding until the physician is satisfied that the patient is no longer liable to spread venereal disease. As in the case of source-finding, however, in the absence of records of numbers of fresh cases seen by doctors it is impossible to assess how many of these proceed regularly through treatment to cure, and what proportion of them default after more or less insufficient treatment.

Health Visitors.—In most areas there are no health visitors and social service workers to deal with venereal disease problems, though they appear to exist for dealing with such matters as tuberculosis and maternity and child welfare. In some of the larger towns, for example Hamburg, Düsseldorf, Hanover, there are health visitors for venereal disease, but these are women (usually nurses) who sit in an office, maintain a card index of examinations of prostitutes, and assist the venereal disease specialist at such examinations.

They seldom or never undertake contact tracing by personal visit or try to win back defaulters to treatment.

Prostitution and Brothels.—The Venereal Disease Law of 1927 makes prostitution a criminal offence and prohibits brothels. In spite of its somewhat legalistic tendency, the German mind finds no incongruity between the provisions of this law and the existence of prostitutes and brothels in every large town in the British Zone. It was calculated recently that Hamburg had about 400 prostitutes in 43 brothels and Brunswick 95 prostitutes in about 16 houses. Kiel, Lubeck, Flensburg, Hanover, and the towns of the Ruhr and the Rhineland all present the same picture. The organization varies in detail, but on the whole follows the same general pattern, and for purposes of description the control and regulation of prostitution and brothels in Hamburg will be selected.

The control and regulation are conducted by a branch of the Police called the "morality police" (sixteen men in Hamburg). The personnel are recruited from the regular police force, and there is a rule that each man must be married and over 35 years of age before acceptance for the "morality police" branch. There is a period of three months' training at a central school in Berlin, where the curriculum contains lectures by lawyers, public health officials, etc. The course is entirely theoretical, and after passing an examination the trainees are returned to their original towns. They are then allocated to a district in company with a senior and experienced member of the force, and learn the job on the apprenticeship basis. In general they wear plain clothes, but hold warrant cards and are paid and administered as part of the normal police force. Their duties consist of patrolling the part of the district assigned to them (which is continually being changed), watching for instances of solicitation, and keeping an eye on women in cafés, bars, restaurants, etc., whose behaviour raises the suspicion of promiscuity, whether professional or amateur. In conjunction with the uniformed police, and, since the British occupation, with the military police, frequent raids on selected districts are made, during which 100 to 150 women of all sorts may be arrested, flung into gaol, and examined next morning at the

hospital reserved for such purpose. In addition to examination rooms and record offices, the hospital has wards containing about 180 beds. All the wards are, in effect, prisons; the inmates are locked in and some of the wards are watched by wardresses drawn from the police.

The venereal disease specialist in charge of this hospital, together with his assistants, carries out the examinations of the women brought there by the civil or military police, and those found to be suffering from venereal disease are hospitalized and treated and not released until the specialist certifies cure. Those not found suffering from venereal disease are required to report again at either weekly or fortnightly intervals for repeat examinations until such times as the specialist no longer requires them to do so.

If, during the period of treatment or examination, the police can get other evidence that the woman is a prostitute, she is then confronted with the alternative of living in a brothel or taking some work and giving up prostitution. The latter alternative is so hard for most girls on account of the triple stigma of prostitution, prison, and possible venereal disease, that it is not surprising that the majority go to swell the population of the brothels. In some cases private charitable organizations maintain homes (called Doors of Heaven !) for the reception and rehabilitation of these women, but there seems to be little public recognition of the need to assume responsibility.

Once a woman has elected or been forced to become a prostitute she must live in a brothel and be medically examined twice weekly by the venereal disease specialist. She is provided with a book with particulars of her name, age, nationality, etc., and bearing a passport photograph. The book also contains pages on which the dates of examinations, results, and initials of the specialist are entered. The book must always be produced on demand by a member of the police.

By means of local police decrees, which are upheld by the local law courts, the employment of prostitutes in cafés, bars, restaurants, theatres, etc., is prohibited. Offending employers are fined for a first offence, and a second offence results in loss of licence to trade. In conformity with these local decrees,

employers in categories similar to the above are compelled to notify to the police the name and address of every female worker newly employed. The "morality police" then go through their card-index of prostitutes to ensure that the employee is not a prostitute.

The brothels are situated in certain streets, and are placed under the general administrative care of one man, who usually has a subordinate for each house. Most of the rooms are exceedingly small, and in them the prostitutes are expected to live, sleep, and work. The women appear to be well-informed regarding their own protection from infection with venereal disease, and each prostitute has her own supply of condoms which, apparently in the majority of cases, she insists must be used by her clients. The brothel district is placed out of bounds to British troops, and periodic raids by the military police take place, during which the houses are searched from cellar to attic. It should be recorded that in Hamburg the military police and the civil authorities co-operate very closely, and this has been the means of detecting and bringing under treatment many women and girls other than registered prostitutes whose way of living would inevitably involve the spread of venereal disease, not only amongst civilians but also amongst British troops.

In places other than Hamburg the routine examination of prostitutes and women suspected of spreading venereal disease is commonly carried out either in the Gesundheitsamt itself or in a building nearby. The examination is often performed by an assistant of the Amsarzt, who need not be necessarily a venereal disease specialist.

In general the routine weekly and twice-weekly medical examination of prostitutes cannot be too strongly condemned. The conditions under which the examinations are carried out militate against the successful search for venereal disease, as the women have ample opportunity for frustrating the purpose of the inspection by previous vaginal douching. It is obviously a strong temptation to any woman who earns her living by prostitution, and who knows that discovery of venereal disease will put her out of business for anything up to three months, to try to arrange that venereal disease shall not easily be found. In result, the so-called examination of prosti-

tutes by doctors is merely prostitution of examination by doctors.

Whatever the attitude of society to prostitution, it is perfectly clear that to the epidemiologist a prostitute without venereal disease is of as little consequence as anybody else without venereal disease, and that a prostitute with venereal disease is of exactly the same concern as any other woman who has venereal disease. All who have it can spread it; therefore the programme is to find them, whoever they are.

The Venereal Disease Problem after the Surrender of Germany

For some two or three years before the unconditional surrender of Germany the principal towns and cities had been constantly subjected to heavier and heavier bombing, with the result that by the time the British forces took over the British Zone of occupation there was widespread destruction of towns, including residential and industrial districts, and almost complete arrest of transport, while communications were maintained almost solely in the most primitive ways since postal services, telephones, and motor transport had all broken down. Unless a doctor had a bicycle his only means of visiting his patients was on foot, and the same applied to patients visiting their doctors. Even the ambulance service had suffered severely, mostly through shortage of fuel, and it was common to see desperately ill patients being conveyed to hospital on hand-carts. The hospitals themselves had often suffered severe damage, either directly to their structure or indirectly to their functions because of interruption of water, gas, and electricity supplies. The virtual stoppage of road and rail transport caused interference with the distribution of all types of medical supplies, with the result that there were often acute shortages of drugs, dressings, anaesthetics, etc. At this time most wounds were bandaged with paper which, in more fortunate times, would have been used only as toilet paper.

As can readily be understood, strenuous efforts were made by the British public health officers to restore the hospitals to something approaching efficiency, and their efforts were supported by those responsible for production and distribution of medical supplies. To tide over the worst period, stocks of drugs, etc. were obtained from captured Wehrmacht stores.

Since the treatment of venereal disease was not concentrated in public clinics attached to hospitals, but, as we have seen, remained predominantly in the hands of private doctors, it is easy to understand that venereal disease specialists, lacking the organization of the hospitals and the priority of attention from British Military Government, were even more hard put to it to maintain a reasonable standard of skill and treatment. An endeavour was therefore made to direct as many patients as possible for treatment to the venereal disease departments of the university and municipal hospitals. In spite of all that could be done, local shortages of sulphathiazole occurred. (Fortunately there was never any shortage of drugs for the treatment of syphilis.) In some cases the German doctors' reaction to restricted supply of sulphathiazole for gonorrhoea was to give each patient some, so that in fact no patient got the optimum dose. This practice had to be forbidden, as otherwise there would probably have been a great increase in sulpha-resistant gonorrhoea.

The standard laid down was 5 g. a day for 5 days. As was noted above, many of the German doctors were still adhering to a routine of 5 g. a day for 2 days, and some opposition was encountered to the instruction to make it 5 g. a day for 5 days. It transpired that I. G. Farben Industrie had had in circulation a leaflet on the uses of sulphathiazole in which the 2-day treatment was recommended. So great was the slavish adherence of many German doctors to this leaflet that its publication was forbidden until it was amended to the optimum dose mentioned above.

In the early days after the occupation of Germany there was so much emergency work that, necessarily, most energy was directed to short-term or *ad hoc* measures. It was always in mind, however, that sooner or later long-term measures would have to be introduced, and as a first step an instruction was sent out in October, 1945, to all German doctors, requiring them (a) to report each week the total number of fresh cases of venereal disease seen by them. It was specifically stated that names and addresses would not be reported. In addition (b) all medical officers of health were instructed to inaugurate and maintain a system of contact tracing, and to keep records of the number of sources reported to them and the number of these brought under treatment. All doctors were instructed to obtain from each new patient with venereal disease as much information as possible about the source of infection, and to

transmit the details without delay to the medical officer of health. All medical practitioners were instructed (c) to notify the names and addresses of venereal-disease defaulters to the medical officer of health, who was made responsible for using the powers given him by German law to bring the defaulters back to treatment. Finally, weekly reports in the case of (a) and monthly reports in respect of (b) and (c) were required to be sent to Military Government public health officers.

These instructions were sent out through the presidents of the various provinces in the British Zone, who represented the highest available constitutional authority, and they were made responsible for the implementation of regulations which affirmed the provisions of existing German law, except in regard to (a), reporting of fresh cases, which, as noted above, had in many States of Germany been the custom before the British occupation.

German venereologists are unanimous that venereal disease increased enormously in Germany during the war, and more particularly since the middle of 1944, but they are unable to do more than speak of impressions. They believe that syphilis is very much more increased than gonorrhoea, an opinion which is confirmed by the carefully kept statistics of Denmark and the other Scandinavian countries. In these countries it has been found that the incidence of syphilis has increased to eight or ten times what it was in 1940. In all probability, having regard to the much greater social and economic disorganization in Germany, especially during 1945, together with the very large movements of population, and, more recently, of German refugees from parts of Germany outside the British Zone, it would not be unwise to say that the number of fresh cases of syphilis is about twenty times that in 1939-40. It is also prudent to forecast that, at least until 1948, the incidence of syphilis will tend to go on increasing, not only in Germany but all over Europe. It happened after the last war when, on the whole, there was very much less disorganization of the social and economic framework and much smaller movements of population than now.

From the end of October, 1945, it became possible to assess the incidence of gonorrhoea and syphilis, not only in total for the Zone, but especially in the population centres such as Hamburg, the Ruhr, and the British Sector of Berlin.

The number of cases of venereal disease in the

British Zone in 4-weekly periods from November, 1945, to September 1946, was :

1945		<i>Syphilis</i>	<i>Gonorrhœa</i>
November	2,352	6,648
December	2,465	6,196
1946			
Dec. 30 to Feb. 2	3,704	9,382
Feb. 3 to March 2	3,335	7,571
March 3 to March 30	3,097	7,057
March 31 to April 27	2,844	6,915
April 28 to June 1	3,963	9,788
June 2 to June 29	3,184	8,724
June 30 to July 27	3,726	9,006
July 28 to Aug. 24	3,949	8,786
Sept. 1 to Sept. 28	4,090	8,553

Venereal Disease in Displaced Persons.—

The care of displaced persons was primarily the responsibility of U.N.R.R.A., who were helped materially by the Army Medical Services and British Military Government. As there was considerable uneasiness concerning the possibility of venereal disease in displaced persons, a tour of displaced persons' camps was accordingly undertaken with the specific object of investigating the venereal disease situation amongst displaced persons, and sufficient camps were visited to account for 60,000 displaced persons, i.e. 10 per cent. of the then displaced persons in that area. All the doctors in these camps were interrogated and their case records inspected, and discussions took place with interested R.A.M.C. officers, who had considerable responsibilities for the medical supervision of displaced persons' camps. It transpired that, though conditions were ideally suitable for the spread of venereal disease, the numbers of fresh cases of gonorrhœa and syphilis were very small, both absolutely and in relation to the populations involved.

Penicillin.—At an early stage it was foreseen that penicillin would prove of great value in Germany on account of its rapid action in the treatment of gonorrhœa, and preliminary steps were taken to obtain supplies which would become available when the German venereal disease organization had reached a stage at which it would be capable of dealing with the implications of what, to them, was an entirely novel method of treatment.

Advisory Committee.—Before the time arrived for the distribution of penicillin a very important step had been taken in the public health organization of the British Zone.

A German Public Health Advisory Committee was formed, consisting of one German public health officer from each of the four provinces of the Zone and one from Hamburg, which counted as a province. The five doctors met each month at the headquarters of the Health Branch of Control Commission, and to them was entrusted the detailed working out of public health policy in the British Zone. It must be clearly understood that the Committee was purely advisory and had no executive functions whatever, but it proved of enormous value.

Soon after its formation the Committee was informed that it was proposed to make certain alterations in the then existing venereal disease organization. They were told that treatment would be available free, without any question of ability to pay, or discussion between private insurance companies and public assistance bodies as to their respective liabilities. They were further informed that, in order to increase the control by the medical officer of health over the venereal disease activities of the private doctor, the latter in each case would have to maintain a confidential register of all patients seen by him suffering with venereal disease. Further it would be the duty of public health authorities to appoint, on a whole-time basis, venereal disease specialists to exercise an overall supervision of all aspects of the venereal disease problem in their area, including a detailed supervision of the treatment of individual cases by the practitioners. These in turn were to be required to submit at suitable intervals copies of their case reports showing progress and treatment. In addition the Advisory Committee was asked to obtain from the universities schedules of their treatment for the venereal diseases, and, with the aid of the professors of venereology, to draw up a standard routine for application to the whole Zone. This fairly considerable task was duly carried out by them and the results of their work were issued as an instruction to all doctors in the British Zone.

It will readily be seen that one object of the above scheme was to facilitate the setting up of clinics for the treatment of venereal disease; and when, early in 1946, it became apparent that supplies of penicillin would be available, further impetus was given to this

tendency. It must be understood that penicillin had at this time a very high black-market value, and therefore any plans for the use of penicillin in the treatment of gonorrhœa had to be considered very carefully, to avoid, as far as possible, leakages into the black market. It was felt that the most prudent course was to select the university venereal disease departments as the only centres where penicillin would be available. As the need became too great for these centres to cope with the problem, further centres in the municipal hospitals of the large towns were set up, but penicillin was never available for private practice.

Most of the selection of centres of specialists was done by the Advisory Committee. As none of the German venereal disease specialists had had any experience with penicillin, arrangements were made through the courtesy

of Sir Edward Phillips, K.B.E., D.M.S. of the Rhine Army, for the selected German specialists to see demonstrations at the Army Venereal Disease Treatment Centres. Detailed instructions were then sent to the chief public health officers of all the provinces and Hamburg, giving not only details of dosage, care of penicillin, etc., but specimen record sheets for the use of the hospital dispensaries and clinics.

The final results of the efforts described above to deal with the venereal disease situation in the British occupied Zone of Germany may not be seen for some time to come.

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DISCUSSION ON THE PRECEDING PAPER

DR. G. L. M. McELLIGOTT (the President) said that, inaccurate though the information given by the methylene blue method might be, he nevertheless thought a single blue stain was probably more informative than a bad Gram stain.

He still felt that at the end of two days one usually knew whether sulphonamides were going to be effective or not. In his own experience of the use of the sulphonamides, when they were at the height of their popularity and the height of their efficiency, and the two went together, a course lasting two or at most three days, gave as good a result as one of fourteen days. He personally had not had much experience of the intravenous sulphonamide treatment of gonorrhœa, but he had had the opportunity, during the war, of using it in a good many cases of meningococcal meningitis in which the immediate response to treatment was far better than that when the drug had been taken by the oral route.

He thought they would all agree that in venereal disease cases treatment must be absolutely free. The American authorities had undoubtedly recognized that, and had said that one of the reasons why the incidence of syphilis was brought down to such a low level in this country and in the Scandinavian countries before the war was that the treatment provided was free. Even now he believed a patient in America had to pay a small fee at each clinic attendance. This must lead to premature default.

LT.-COL. WILLCOX asked how rigorously and how conscientiously the medical examination of prostitutes was carried out, and whether Dr. Curtis had any idea how many contacts the average prostitute had without contracting some disease.

He said he understood that penicillin was in general use for treating gonorrhœa, but not for syphilis. He would like to know what the schedule of treatment had been for syphilis when Dr. Curtis was in Germany. They had been told what it was before the war, but he did not understand what it was at the present time, or whether it was uniform throughout the zone. He would also like to know whether there was any equivalent of the Y.15 traveller's booklet for patients moving from zone to zone, and whether the Russians were co-operating with this system of treatment.

DR. MARSHALL said that continental public health services for venereal disease had always differed from our own. With regard to displaced persons, the French in 1945 did make some attempt to find out what had happened to the men who had been taken into Germany for forced labour and they tried, without much success, to do serum tests on the men coming back from Germany. Those coming through Paris were subjected to medical examination, and blood samples were taken. Naturally there were a large number of people in transit who made their own way home, but it was possible to do many thousands of blood tests. The method in the first instance was a simple and quick slide test of the Kline variety, and a photographic picture of the result of the test was made, which was eventually appended to the man's papers. If a positive result was obtained the authorities intended to look out for the man and have further tests. The number of positive results they found was relatively small—one or two per thousand. The system unfortunately failed because the men, after leaving the distribution centres, scattered all over